


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Printed: 04/25/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/25/2018
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NAME OF PROVIDER OR SUPPLIER ALLEGHANY HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET CLIFTON FORGE, VA 24422
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>Surveyor: 34730 Construction Type: II (000)</p> <p>Description of structure: The building is a one story structure with unprotected steel bar joists and concrete floors. The porch is wood framed with a masonry roof.</p> <p>Sprinkler status: Fully sprinklered with an NFPA 13 supplied by the municipal water system, and QR sprinklers. The exterior sprinklers are supplied by an anti-freeze loop with a back flow prevention device and sectional control valves with tamper switches.</p> <p>An unannounced LSC revisit to the standard survey conducted on 03/14/2018 was conducted on 04/25/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 (Existing) regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.</p> <p>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)</p>	{K 000}	<p>Preparation, submission and implementation of this plan of correction does not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. Our plan of correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.</p>	
{K 918} SS=F	<p>Electrical Systems - Essential Electric System CFR(s): NFPA 101</p> <p>Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a</p>	{K 918}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 5/2/18
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER ALLEGHANY HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET CLIFTON FORGE, VA 24422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 918}	<p>Continued From page 1</p> <p>process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 34730</p> <p>Based on observation and inspection the facility failed to maintain the generator system. This has the ability to affect all occupants of the building.</p> <p>Findings include:</p> <p>On 4-25-18 at approximately 9:15 AM it was observed through observation and inspection that documentation could not be provided to show that</p>	{K 918}	<ol style="list-style-type: none"> 1. The main and feeder circuit breakers will be tested according to manufacturer requirements on May 8, 2018 instead of April 9, 2018 by Electric Power Systems, due to weather conditions. Facility is requesting a time limited waiver due to the inability to complete test as planned. The generator was exercised for 4 continuous hours. 2. Breakers and the generator will be checked for proper inspections and testing. 	

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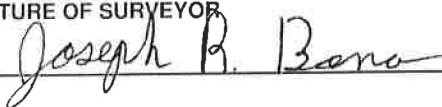
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{K 918}	Continued From page 2 main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. The Administrator and Maintenance Director witnessed this evidence by observation and interview.	{K 918}	<p>3. Main and feeder circuit breakers will be inspected annually according to manufacturer requirements. The generator will be exercised for 4 continuous hours every 36 months by maintenance director or designee.</p> <p>4. Circuit breaker test and generator exercise will be reviewed and discussed in QAPI to ensure completed when required.</p> <p>5. Date of completion May 8, 2018.</p>	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 495141	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 4/25/2018	Y3
NAME OF FACILITY ALLEGHANY HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET CLIFTON FORGE, VA 24422		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	04/25/2018	LSC K0324	04/25/2018	LSC K0353	04/25/2018
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0362	04/25/2018	LSC K0363	04/25/2018	LSC K0712	04/25/2018
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0911	04/25/2018	LSC K0921	04/25/2018	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR 	DATE 04-25-2018
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 3/14/2018	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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